

LOS ANGELES COUNTY MEDICAL CENTER NURSES ALUMNI ASSOCIATION

Membership Application/ Donation Form

INSTRUCTIONS: Please complete and print clearly the member information requested below, then enter the amount of funds you are sending for each of the desired sections. Mail this form with a check payable to:

LACMC Nurses' Alumni Association
c/o LAC College of Nursing and Allied Health
1237 North Mission Road, Box 348 & 349
Los Angeles CA 90033

MEMBER INFORMATION:

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Name on Diploma: _____ Graduation Year: _____
Phone: () _____ Email: _____

DUES/ALLOCATION:

Dues are \$20.00 / calendar year. A Life Member is 25 years of membership (or \$500.00 accumulated dues).

DUES: \$ _____

SCHOLARSHIPS:

Freshman Books \$ _____

Annie M. Yates \$ _____

Carol Kelly \$ _____

DONATION:

Alumni Fund \$ _____

Special Projects \$ _____

You may pay tribute to a friend or loved one with your donation:

Amount: \$ _____

In Honor/Memory of _____ for _____

Name of Honoree

Reason

Please indicate if you wish to have us notify someone of your donation.

Name _____ Address _____

City _____ State _____ Zip Code _____

PURCHASE:

Book Looking Back – A Century of Nursing 1895-1995 Quantity: ____ X\$50 each= \$ _____

Video 100 Years of Distinction, 1895-1995 Quantity: ____ X\$15 each= \$ _____

TOTAL ENCLOSED \$ _____

UPDATE: Please let us know what you have been up to since graduation: